DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445047	A. BUILDING _____ B. WING _____	08/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILITATION	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual Recertification survey and complaint investigation of #28481 conducted on August 1 to 3, 2011, at Imperial Gardens Health and Rehabilitation, deficiencies were cited in relation to the complaint under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	F 000 Without admitting or denying the citations rendered, Imperial Gardens Health and Rehabilitation alleges it will be in compliance with all deficiencies by the end of the day on September 6, 2011.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	F 157 Imperial Gardens will notify appropriate parties when residents condition warrants notification. On July 27, 2011 the DON and ADON met with the family of resident # 29 and discussed in detail the status of the resident's condition. Both the DON and ADON informed the daughter that the wound had not made a significant change until the morning that she had seen the resident. The ADON spoke with the Hospice nurse on July 27, 2011 and she assessed the wound on July 28, 2011 and spoke with her asking her to talk with the family regarding the wound since she had been following its status and had not seen the dramatic change either until July 28, 2011. After the initial visit with the daughter, the ADON met with the family every day to ensure that they were satisfied with the care being provided to the resident. Resident # 29 expired on 8/7/2011. The ADON spoke with the wound care nurse on August 16, 2011 and reviewed all residents with wounds to ensure there were no further issues of wounds showing signs of worsening. The ADON issued a written warning on August 16, 2011 to the wound nurse for failure to notify the family of the	9/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rene Sharp, Administrator (Interim) TITLE: 9/2/11 (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify a family of a change in resident condition for one (#29) of twenty-nine residents reviewed. The findings included: Medical record review revealed resident #29 was admitted to the facility on December 19, 2008, with diagnoses to include Diabetes Mellitus, Hypertension, Congestive Heart Failure, Dementia, Atrial Fibrillation, and Pacemaker insertion. Review of the Minimum Data Set dated July 3, 2011, revealed the resident required total assistance with transfers, dressing, bathing; had to be fed by staff; was incontinent of bowel; had a urinary catheter in place; and had a stage II pressure ulcer. Medical record review of nursing notes dated May 14, 2011, revealed "In House Acquired Pressure Ulcer stage 2 coccyx; healed, treatment discontinued". Continued medical record review of nursing notes dated May 21, 2011, revealed "Informed Wound Care Nurse resident has skin breakdown on lower back/coccyx area. It is in the area of prior wound". Review of nursing notes dated June 2, 2011, revealed the pressure ulcer on the coccyx was "... stage II and measured 2 cm (centimeters) x 1 cm x < (less than) 1/8 cm	F 157	change in the wound for resident # 29 the morning in question. (Attachment 1) Residents with any changes in condition have a potential to be effected. Beginning on August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding notification to appropriate parties when a resident has a change in condition This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011 New or returning licensed staff members including licensed agency staff will receive education on notification to appropriate parties when a resident has a change in condition prior to working on the units by the Nurse Educator, IDON or designee. The IDON or designee reviews the 24 hour report daily. This report identifies residents who have a change in condition or treatment based on physician orders. The IDON or designee will review daily to assure appropriate parties are notified in a timely manner when such notification is warranted. The 24 hour report is automatically generated from the Electronic Charting System (ECS). Additionally, the IDON or designee reviews changes in resident condition or treatment in stand up meetings with the Team Leaders and other members of the IDT (i.e. therapy, social service, wound nurse). These daily meetings discuss residents with changes in	

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F 157	Continued From page 2 with serosanguinous (bloody) drainage and irregular wound edges"... Medical record review of physician's telephone orders dated May 30, 2011, revealed "Cleanse wound to coccyx with wound cleanser; pat dry with 4x4 gauze; cover with hydrocolloid dressing; change every 5 days and as needed until resolved". Continued review of physician's orders dated June 2, 2011, revealed "Cleanse wound to coccyx with wound cleanser; apply transparent film or thin foam dressing; change every 3 days and as needed for 14 days then reassess". Medical record review of nursing notes dated June 15, 2011, revealed the pressure ulcer on the coccyx measured 6.5 cm x 4 cm x <1/8 cm and had serous drainage. Continued medical record review of nursing notes dated June 22, 2011, revealed the pressure ulcer on the coccyx measures 4.5 cm x 6 cm x <1/8 cm with serous drainage. Continued medical record review of nursing notes dated July 5, 2011, revealed the pressure ulcer on the coccyx measured 2 cm x 6 cm x 1/8 cm with serosanguinous drainage; had 5% slough, 5% epithelization, and 90% granulation. Medical record review of physician's orders dated July 5, 2011, revealed "Cleanse wound with wound cleanser; apply Solosite gel to wound bed and cover with foam dressing. Change daily and as needed". Medical record review of nursing notes dated July 26, 2011, revealed "Call Placed To Attending physician regarding increased wound drainage. New orders received and noted". Further medical	F 157	condition or treatment. If an appropriate party has not been informed of the change in condition or treatment, the IDON, Team Leader Nurse or designee follows up with the appropriate parties immediately. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 157	Continued From page 3 record review of nursing notes dated July 26, 2011, revealed "... dressing removed due to saturation. Area cleansed and wound treatment done per order". Medical record review of physician's orders dated July 27, 2011, revealed "Cleanse wound to coccyx with wound cleanser. Apply calcium alginate to wound bed. Apply foam dressing. Change three times a day at 9:00 a.m., 5:00 p.m., and 1:00 a.m.". Continued review of physician's orders dated July 28, 2011, revealed "Cleanse wound to coccyx with wound cleanser. Apply calcium alginate to wound bed. Apply foam dressing; Change twice a day at 7:00 a.m., and 3:00 p.m.". Medical record review of nursing notes dated August 1, 2011, revealed pressure ulcer to coccyx measured 3.5 cm x 4 cm x 1/2 cm; had serous drainage; deep purple to area surrounding ulcer; and had slough in the base of the wound". Medical record review of nursing notes revealed no documentation the family was notified of the deterioration in the pressure ulcer on the resident's coccyx. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on June 3, 2011, at 9:15 a.m., in the DON's office revealed the ADON is a Certified Wound Care Nurse. Continued interview revealed the ADON saw the wound on July 25, 2011, which had no drainage and was not deep. Further interview revealed the resident had "... pools of exudate under the skin which leaked out overnight so the wound became a crater by the next morning".	F 157		

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F 157	Continued From page 4 Further interview with the DON revealed the daughter was told the only thing the facility failed to do was notify the family when the wound because worse. Continued interview confirmed the family was not notified of the deterioration in the status of the pressure ulcer on the resident's coccyx.	F 157		
F 176 SS=D	COMPLAINT #28481 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess for self-administration of medications for one (#28) of twenty-nine residents reviewed. The findings included: Resident #28 was admitted to the facility on September 8, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease, Vascular Dementia, and Congestive Heart Failure. Medical record review of the Minimum Data Set (MDS) dated May 11, 2011, revealed the resident had moderately impaired cognitive skills.	F 176	**F 176** Imperial Gardens Health and Rehabilitation will assess residents for self-administration of medication and only those who are assessed as able to self administer medications will be permitted to do so. The IDON spoke with the attending physician on August 3, 2011 regarding resident # 28 being left unattended with his nebulizer treatment running. A medication error report was initiated by the IDON immediately on August 3, 2011. The physician determined the resident needed no further intervention, and stated to continue the medication with the next scheduled treatment. No adverse outcomes were noted by the staff or the physician. Immediately thereafter the IDON gave verbal education and training to the LPN who administered the nebulizer treatment to resident # 28 regarding administering respiratory treatments and staying with the resident until respiratory treatments are completed. The written instruction was provided to the LPN by the IDON on August 16, 2011.	

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F 176	Continued From page 5 Medical record review of the physician's orders dated August 2011, revealed "...(DuoNeb) Ipratropium-Albuterol (bronchodilators) 0.5 mg (milligrams)/3ml (milliliter) 0-2.5(3)mg/3 ml solution inhalation via nebulizer bid (two times a day)...for chronic bronchitis..." Medical record review revealed no documentation the resident had been assessed for self-administration of medications. Observation on August 3, 2011, from 9:06 a.m., until 9:18 a.m., revealed the resident asleep in a recliner, with the feet elevated. Continued observation revealed a nebulizer mask was located on the resident's face. Continued observation revealed the top of the nebulizer mask was approximately one inch above the eyebrows, and the bottom of the mask was in the resident's mouth. Continued observation revealed no staff member was present on the hallway of the resident's room. Observation on August 3, 2011, at 9:18 a.m, revealed Licensed Practical Nurse (LPN) #7 entered the resident's room, and removed the nebulizer mask. Interview with LPN #7, at the time of the observation revealed LPN #7 had not applied the nebulizer mask on the resident. Continued interview revealed LPN #8 was responsible for applying the nebulizer treatment and mask to the resident. Interview on August 3, 2011, at 9:20 a.m., with LPN #8, on a different hallway, revealed the nebulizer treatment had been placed on the resident approximately 20-25 minutes earlier.	F 176	Resident # 28 is has his medication administered by the nurse. Beginning August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding appropriate medication passage including respiratory treatments. This in-service included policy and procedures related to self administration of medications. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on medication pass including respiratory treatments prior to working on the units by the Nurse Educator, IDON or designee. Additionally, medication pass audits are being conducted weekly on licensed nursing staff including licensed nursing agency staff by the IDON, Nurse Educator and RN Team Leaders. This audit tool was revised in April, 2011 and weekly audits began on August 8, 2011. These audits check to assure residents receive their medications appropriately. If an error is found it is corrected immediately by the person completing the audit. (Attachment 3) The results of medication pass audits are given to the IDON. The IDON or designee then tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining	

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F 176	Continued From page 6 Continued interview revealed LPN #8 was unaware if the resident had been assessed for self-administration of medications. Review of the facility's policy Self-Administration of Medications revealed "Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team had assessed the resident and determined that this practice is safe for the resident and other residents of the facility..." Interview on August 3, 2011, at 9:25 a.m., with the Quality Improvement Coordinator, in the Admissions office, confirmed the resident had not been assessed for self-administration of medications.	F 176	Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to assess for the use of a restraint for one (#12) resident of twenty-nine residents reviewed. The findings included: Resident #12 was admitted to the facility on January 15, 2010, with diagnoses including Major	F 221	**F 221** Residents will be assessed for restraints prior to use by the licensed nurse. A restraint assessment on resident # 12 was completed by the licensed nurse on August 13, 2011 to determine the need for the wheelchair self-release seat belt. (Attachment 4) Beginning August 8, 2011 prior to a restraint being placed on a resident the IDON or designee must be notified. The IDON or designee will review information to assure a pre-restraint assessment is conducted, is warranted and a physician order is written prior to giving permission for a restraint to be placed on a resident. Beginning on August 16, 2011 all team leader nurses were in-serviced by the IDON, and LPN and the Nurse Educator regarding pre-restraint assessments prior to	

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F 221	Continued From page 7 Depressive Disorder, Hypertension, Arteriosclerotic Dementia, and Cerebrovascular Accident. Medical record review of a physician's order dated February 16, 2011, revealed "...Self Release wheelchair belt with alarm..." Medical record review of a Rehab Screen dated February 16, 2011, revealed, "Type of Screen...Fall...observed for transitions, transfers, and belt buckle detachment. Pt. (patient) was unable to push the unlocking mechanism on the belt in order to release self from w/c (wheelchair) after multiple tries. Pt. could not follow verbal instruction and was unable to place finger on appropriate area in order to release the belt...The application of a belt buckle currently meets the definition of a restraint due to pt cognitive status...Therapy not recommended at this time..." Review of the facility policy, Physical Restraints, revealed, "...a Pre-Restraint Assessment will be completed to determine the least restrictive measures..." Medical record review revealed no pre-restraint assessment had been completed for the self release wheelchair belt with alarm. Observation on August 1, 2011, at 1:15 p.m., revealed the resident seated in a wheelchair, in the resident's room, with a self release belt alarm in place. Interview on August 3, 2011, at 9:50 a.m., with the Assistant Director of Nursing, in the Director of Nursing office, confirmed a pre-restraint	F 221	using a restraint. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on pre-restraint assessments. Residents with existing restraints are identified by the Restraints/Physical forms generated from ECS. This form shows all residents using physical restraints or assistive devices. The Team Leader Nurse pulls this report form daily and conducts visual checks throughout the day to assure appropriate restraints or assistive device are on and in working order. Additionally, the Team Leader Nurse reviews all residents visually on a daily basis to assure restraints are not used on a resident without a physician order. This Restraint/Physical form is given to the IDON or designee daily by the RN/LPN. Additionally, the IDON or designee reviews the 24 hour report, which pulls all new physician orders regarding restraints from the ECS to the report. The IDON or designee reviews all new physician orders for restraints. This is a double check to assure they have been called prior to the restraint being placed on the resident. The results of the restraint audits are given to the IDON or designee The IDON or designee then tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team	

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F 221	Continued From page 8 assessment had not been completed for the use of the self release wheelchair belt with alarm.	F 221	composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two (#9, #29) of twenty-nine residents reviewed. The findings included: Resident #9 was admitted to the facility on September 11, 2008, with diagnoses including	F 280	**F 280** Imperial Gardens will revise care plans when appropriate. The plan of care for resident # 9 was revised on August 2, 2011 by the LPN to reflect that Hospice was discontinued. (Attachment 6) A physician order for a trial of a self-release belt was written on July 11, 2011. The order did not include to remove the soft waist belt therefore the order was unclear. On July 20, 2011 there is a nurse's note stating a self-release belt in place, no attempts to get out of chair. On August 2, 2011 the self-release belt was replaced. According to the nurses' notes resident # 9 has not experienced a fall since the self-release belt was in place on August 2, 2011. The plan of care for resident # 29 was not revised and the LPN MDS nurse was counseled on August 6, 2011 by the IDON. The resident expired on August 7, 2011. (Attachment 7)	

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F 280	Continued From page 9 Urinary Tract Infection, Congestive Heart Failure, and Senile Dementia. Medical record review of the fall risk assessment dated June 8, 2011, revealed the resident was at high risk for falls. Medical record review of a physician's order dated February 14, 2011, revealed "D/C (discontinue) Hospice Care per family request." Medical record review of a physician's order dated July 11, 2011, revealed "D/C soft waist belt. Trial of self-release belt when in W/C (wheelchair) D/T (due to) unsteadiness and unassisted transfer attempts..." Medical record review of the Care Plan reviewed on July 13, 2011, revealed "Resident is a hospice patient collaborate with hospice staff with concerns and problems...Resident to have soft waist belt in place in w/c..." Observation on August 2, 2011, at 8:15 a.m., revealed the resident seated in a wheelchair, in the resident's room, without the self-release wheelchair belt in place. Interview on August 2, 2011, at 11:10 a.m., with Licensed Practical Nurse (LPN) #4, in the admissions office, confirmed the Care Plan was not revised to discontinue hospice and the soft waist belt, and to include the self-release wheelchair belt. Medical record review revealed resident #29 was	F 280	Beginning August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding updating the plan of care to meet current resident needs. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on updating the plan of care to meet current resident needs prior to working on the units by the Nurse Educator, IDON or designee. The MDS nurse will review all resident's plans of care and make changes to reflect the residents current condition no later than August 18, 2011. Thereafter, resident plans of care will be updated by the Team Leader Nurse and the MDS Nurses no less than quarterly and with any change that warrants a new change in their current plan of care. The RN/LPN will visually monitor the resident daily for any changes in condition and will report such changes to the IDON or designee daily. The MDS Nurse or designee will review the 24 hour report, which shows all new physician orders, for any resident changes daily. The RN/LPN and MDS Nurse will review these audits and update the resident plan of care accordingly.	

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F 280	Continued From page 10 admitted to the facility on December 19, 2008 with diagnoses to include Diabetes Mellitus, Hypertension, Congestive Heart Failure, Dementia, Atrial Fibrillation, and Pacemaker Insertion. Review of the Minimum Data Set dated July 3, 2011, revealed the resident required total assistance with transfers, dressing, bathing; had to be fed by staff; was incontinent of bowel; had a urinary catheter in place; and had a stage II pressure ulcer. Medical record review of nursing notes dated May 14, 2011, revealed "In House Acquired Pressure Ulcer stage 2 coccyx; healed, treatment discontinued". Continued medical record review of nursing notes dated May 21, 2011, revealed "Informed Wound Care Nurse resident has skin breakdown on lower back/coccyx area. It is in the area of prior wound". Review of nursing notes dated June 2, 2011, revealed the pressure ulcer on the coccyx was "... stage II and measured 2 cm (centimeters) x 1 cm x < (less than) 1/8 cm with serosanguinous (bloody) drainage and irregular wound edges". Review of the nursing care plan dated May 4, 2011, revealed the problem of "Impairment of Skin Integrity" manifested by "Protective care - occasional excoriated buttocks and peri area" with the nursing approaches of "Assess skin condition daily and note any changes. Treat as ordered. Monitor diet intake. Ensure adequate hydration". The nursing care plan had not been updated to reflect the reappearance of the pressure ulcer on the coccyx; the treatment; the need to turn the resident every two hours to keep off the coccyx area; and to keep the resident off the back except for meals.	F 280	The results of the these audits are given to the IDON or designee. The IDON or designee will assure plans of care are updated accordingly. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 280	Continued From page 11 Interview with the Director of Nursing (DON) on August 3, 2011, at 9:15 a.m. in the DON's office, confirmed the nursing care plan had not been updated. C/O TN 28481	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of the Nursing Drug Handbook, observation, and interview, the facility failed to ensure licensed nursing staff appropriately administer medications for two (#14, #19), and failed to appropriately identify and check the heart rate for one (#6) of twenty-nine residents reviewed. The findings included: Resident #14 was admitted to the facility on March 27, 2009, with diagnoses including Fractured Femur, Diabetes, Bronchitis, Hypertension, and Alzheimer's Disease. Medical record review of the nursing notes dated May 5, 2011, at 8:04 a.m., revealed "Call placed to attending physician...regarding medication error. This resident was given resident (resident #16's) medication. Result: no new orders."	F 281	F 281 Medications will be administered to resident according to professional standards of care. Upon notification to Nursing Administration by the survey team of the medication error, the (LPN # 6) nurse was immediately removed from administering further medications. She was placed on suspension pending a complete investigation. She was terminated on August 8, 2011. Nurses administering medications to residents # 6, #14 and #19 have been monitored by the Nurse Educator and designee during medication pass to assure these residents are receiving their medications appropriately. Including checking the pulse rate for resident # 6 prior to administering Digoxin and identifying resident by picture identification prior to administering medications per facility protocol. All residents receiving medications have the ability to be effected. On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding appropriate medication passage including resident identification and checking vital signs where appropriate (i.e. Pulse before Digoxin) prior	

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F 281	Continued From page 12 Review of documentation provided by the facility, dated May 5, 2011, revealed Licensed Practical Nurse (LPN) #1 administered following medications in error to resident #14: Namenda (medication for treatment of dementia) 10 mg (milligrams); Seroquel (antipsychotic) 25 mg; Metamucil (laxative, no dosage indicated); Miralax (laxative, no dosage noted); Aspirin 81 mg; Calcium (no dosage noted); Colace (stool softener, no dosage noted); Estrace (estrogen, no dosage noted); Vitamin E (no dosage noted); and Decubivite (vitamin). Continued review of documentation provided by the facility revealed LPN #1 was being oriented/precepted by LPN #3, and LPN #3 had discovered the error by double checking behind LPN #1. Review of a statement dated May 5, 2011, signed by LPN #1 revealed "I thought I was giving meds to a pt (patient) just seen by my preceptor." Review of the facility's policy Medication Administration revealed "...Identification of the resident must be made prior to administering medication to the resident by checking the ID (identification) bracelet and/or photo identification card in the MAR (Medication Administration Record)..." Interview on August 1, 2011, at 2:45 p.m., with LPN #3, in the conference room, revealed LPN #1 was no longer employed by the facility. Continued interview revealed on May 5, 2011, LPN #3 had instructed LPN #1 to administer resident #16's medications. Continued interview revealed LPN #3 had exited resident #14's room after checking the resident's vital signs, when instructing LPN #1 to administer resident #16's medications. Continued interview revealed LPN	F 281	to the administration of medications. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 22, 2011. New or returning licensed staff members including licensed agency staff will receive education on medication pass including resident identification and vitals prior to administering medications (where appropriate) prior to working on the units by the Nurse Educator, IDON or designee. The Nurse Educator, IDON or designee will conduct medication audits during normal medication pass times on RN/LPNs weekly X 4 then monthly X 3. If any errors are noted they will be corrected by the Nurse Educator, IDON or designee immediately to assure the resident does not get the incorrect medication. A medication error report will be initiated by the person conducting the audit and the IDON or designee will be notified. The results of the these audits are given to the IDON or designee. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 281	Continued From page 13 #3 had continued to check vital signs on additional residents while LPN #1 administered the medications. Continued interview revealed shortly after instructing LPN #1 to administer the medications to resident #16, LPN #3 had observed LPN #1 exit resident #14's room. Continued interview revealed LPN #3 had spoken with LPN #1 as LPN #1 returned to the medication cart, and LPN #1 thought had administered the medications to resident #16. Continued interview revealed LPN #1 did not ask the resident's name prior to administering the medications, confirmed LPN #1 failed to correctly identify the resident prior to administering the medications, and confirmed resident #14 received resident #16's medications in error on May 5, 2011. Observation on August 2, 2011, at 7:25 a.m., revealed LPN #6 preparing to administer medications. Observation revealed LPN #6 stated was going to administer resident #6's medications, who received tube feedings and was in the B bed (bed next to the window). Continued observation revealed LPN #6 stated had been pulled from another unit to administer medications and was unfamiliar with the residents. Continued observation revealed LPN #6 crushed the following medications to administer through the feeding tube: Ocular vitamin; Decubivite (vitamin) 1 tablet; Sertraline (antidepressant) 50 mg; Hydrocodone-Acetaminophen 5 mg-500 mg (narcotic pain medication); and Digoxin (heart medication) 0.125 mg. Continued observation revealed a computerized medication system and resident #6's picture was on the computer screen to identify the resident. Continued observation	F 281		

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F 281	Continued From page 14 revealed LPN #6 entered the resident's room and went to the bedside of resident #27 (roommate of resident #6), located in the A bed, nearest to the door. Continued observation revealed the resident #27 had an identification band located on the right wrist. Continued observation revealed LPN #6 did not check resident #27's identification band, located on the right wrist. Continued observation revealed LPN #6 lifted resident #27's gown, and resident #27 asked "What are you doing?" and LPN #6 replied "I'm looking for your feeding tube." Continued observation revealed the resident did not have a feeding tube, and LPN #6 returned to the medication cart and stated would have to ask the Registered Nurse what had happened to the resident's feeding tube. Interview on August 2, 2011, at 7:35 a.m., with LPN #6, in the hallway, confirmed the resident's roommate's identification band on the wrist was not checked, the picture identification on the computerized MAR had not been checked, and confirmed the facility's policy for identifying residents prior to medication administration had not been followed. Observation on August 2, 2011, at 7:52 a.m., revealed LPN #6 administering medications to resident #6. Continued observation revealed LPN #6 administered Digoxin (medication to treat heart failure and irregular heart rhythms) 0.125 mg, through a feeding tube, to the resident, without checking the resident's heart rate/pulse prior to administration of the medication. Continued observation revealed LPN #6, flushed the resident's feeding tube after administering the medication, applied antibiotic ointment to the resident's feeding tube site, then checked the	F 281		

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F 281	Continued From page 15	F 281		

resident's pulse. Interview with LPN #6, at the time of the observation revealed resident #6's pulse rate was seventy-eight.

Review of the Nursing 2008 Drug Handbook revealed "...digoxin...before giving drug, take apical-radial pulse for 1 minute. Record and notify prescriber of significant changes...Excessively slow pulse rate (60 beats/minute or less) may be a sign of digitalis toxicity. Withhold drug and notify prescriber..."

Interview on August 2, 2011, at 8:15 a.m., with LPN #6, in the resident's room, revealed the pulse was to be checked prior to the administration of Digoxin. Continued interview revealed if the heart rate was below sixty the Digoxin was not to be administered, and confirmed the resident's pulse was not checked prior to the administration of Digoxin.

Medical record review revealed resident #19 was admitted to the facility on January 23, 2007 and readmitted on November 26, 2010, with diagnoses to include Atrial Fibrillation, Systolic Heart Failure, Hypertension, Failure to Thrive, Osteoporosis, Osteoarthritis, and Dementia. Review of the Minimum Data Set (MDS) dated June 9, 2011, revealed the resident scored 15 on the BIMS (Brief Interview for Mental Status) with a score of 15 signifying the resident was cognitively intact.

Medical record review revealed resident #20 was admitted to the facility on October 6, 2010, with diagnoses to include Cerebrovascular Accident, Patient Foramen Ovale, Hypertension, Osteoarthritis, Left Hemiplegia, and Dementia.

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F 281	Continued From page 16 Review of the MDS dated July 12, 2011, revealed the resident scored a 14 on the BIMS. Review of a facility investigation of an incident occurring May 15, 2011, revealed a medication error had occurred. Continued review revealed the incident occurred in the dining room where the LPN called the name of resident #20 but resident #19 answered. Further review revealed the LPN "showed the med (medicine) cup with ... (named resident #20) name and room # (number) on it. (Resident #19)... asked what the med was, I told ... and ... took it. Then ... (named Certified Nursing Assistant) told me that wasn't ... (named resident #20). I thought they looked similar". Continued review of the investigation report revealed the medication administered was Verapamil (antihypertensive, control of angina). Continued review of the investigation report revealed the Director of Nursing (DON) classified the medication incident as "Incorrect Patient" and the cause of the medication incident to be "Patient not identified". Medical record review of nursing notes for resident #19 dated March 15, 2011, revealed "Call placed to Nurse Practitioner regarding medication incident. New orders received and noted. Hold 1700 (5:00 p.m.) doses of Coreg (antihypertensive, congestive heart failure) and BiDil. Check bp (blood pressure) q2h (every two hours) until 7:00 a.m. May 16, 2011. Interview with the Director of Nursing (DON) on August 2, 2011, at 2:30 p.m., in the conference room revealed the LPN involved in the incident was no longer employed by the facility. Continued	F 281		

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F 281	Continued From page 17 interview revealed the DON confirmed medication intended for resident #20 was administered to resident #19.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, and interview, the facility failed to implement the care plan for one (#15) resident of twenty-nine residents reviewed. The findings included: Resident #15 was admitted to the facility on November 16, 2010, with diagnoses including Diabetes, Bipolar Affective Disorder, and End Stage Renal Disease. Medical record review of the care plan dated May 25, 2011, revealed, "...vs (vital signs) before and after dialysis Monitor venous access for bleeding immediately after patient returns from dialysis..." Medical record review of the nurse's notes dated July 7, 12, 16, 21, 26, and 30, 2011, revealed no documentation of complete vital signs, or dialysis access site condition. Review of the facility policy, Renal Dialysis Documentation, revealed, "...Documentation will	F 282	**F 282** Care Plans will be implemented and followed. Imperial Gardens has 4 residents receiving dialysis. Pre and post dialysis assessments were completed by the RN/LPN per facility protocol on dialysis residents on August 2, 2011. The dialysis protocol was reviewed and revised on August 4, 2011 by the IDON. This protocol includes obtaining vital signs before and after dialysis and to assess the access site for bleeding, pain, edema and a "thrill". Imperial Gardens currently has four residents on dialysis. Pre and post dialysis assessments were completed per facility protocol on dialysis residents by the RN/LPN. This practice will be ongoing when the resident goes to or arrives from dialysis. (Attachment 8) Beginning August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding the dialysis protocol including taking complete vitals pre and post dialysis and checking the access site for bleeding, pain, edema and a "thrill". This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 30, 2011. New or returning licensed staff members including licensed	

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F 282	Continued From page 18 include: Vital Signs...Dialysis access site condition..." Interview on August 3, 2011, at 9:20 a.m., in the conference room, with Registered Nurse (RN) #3, confirmed there was no documentation that complete vital signs and assessment of the dialysis access site had been completed.	F 282	agency staff will receive education on the dialysis protocol prior to working on the units by the Nurse Educator, IDON or designee. (Attachment 9) The RN/LPN will be monitored by the Team Leaders daily for residents going to and from dialysis to assure complete vital signs are obtained and the access site is assessed prior to and upon returning from dialysis. The results of these audits will be forwarded to the IDON or designee on the days the resident goes to dialysis. (Attachment 5) The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to assess bladder retraining for two (#3 and #5) of twenty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility on April 21, 2011, with diagnoses including Syncope, Hypertension, Dementia, and a History of Falls. Medical record review of the Minimum Data Set dated April 28, 2011, revealed the resident	F 315	**F 315** Residents will receive appropriate treatment and services to restore as much normal bladder function as possible. A bladder assessment was completed on resident # 3 and # 5 by the RN Team Leader on August 13, 2011. (Attachment 10 and 11) All residents have the ability to be effected.	

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F 315	Continued From page 19 required moderate assistance with decision making, had short term memory problems, required moderate assistance with transfers, and was frequently incontinent of bladder. Observation and interview on August 1, 2011, at 8:15 a.m., revealed the resident sitting in a wheel chair, in the resident's room, watching the television. Interview, at that time, revealed the resident was alert and oriented to the date and time. Review of the facility's Incontinence Management Policy revealed, "...A Urinary Assessment will be performed on all residents at the time of admission or whenever there is a change in cognition..." Medical record review revealed no documentation the Bladder Assessment had been completed. Interview with the Team Leader (Nurse Manager) on the West Hall, on August 2, 2011, at 11:00 a.m., at the nursing station, confirmed the resident had not been assessed for bladder retraining. Resident #5 was admitted to the facility on May 16, 2011, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, Osteoarthritis, and Cellulitus of the Leg. Medical record review of the Minimum Data Set dated July 13, 2011, revealed the resident required no assistance with decision making, had no memory problems, required moderate assistance with transfers, and was occasionally incontinent of bladder.	F 315	On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding obtaining bladder assessments. This began the one hundred percent education to all licensed nursing staff. The education was completed with all licensed staff on August 30, 2011. New or returning licensed staff members including licensed agency staff will receive education on the bladder assessments prior to working on the units by the Nurse Educator, IDON or designee. Residents will have a bladder assessment completed on admission and with a change in condition by a licensed nurse. The completion of bladder assessments will be monitored by the Nurse Educator, Team Leaders and/or IDON or designee when assessments are due (on new admissions, with a change in condition). The RN/LPN also conducts visual checks on residents throughout the day and works with the nursing assistants reviewing their voiding patterns. The Team Leader oversees this process daily. Results of bladder assessments are reviewed by the Team Leaders and appropriate interventions are implemented per physician orders or per facility protocol. The IDON or designee tracks and trends these results and reviews the overall effectiveness of the system and reviews the outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse,	

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	445047	A. BUILDING _____ B. WING _____	08/03/2011

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F 315	Continued From page 20 Observation and interview on August 2, 2011, at 8:00 a.m., revealed the resident lying in bed, neatly dressed and watching television. Interview at that time revealed, "I can now ambulate with my walker in PT (Physical Therapy). I am so happy." Interview with the resident on August 2, 2011, at 9:00 a.m., in the resident's room, revealed, "I know when I have to go (void), but sometimes I cannot hold it." Medical record review revealed no documentation the Bladder Assessment had been completed. Interview with the Team Leader (Nurse Manager) on the West Hall, on August 2, 2011, at 11:00 a.m., at the nursing station, confirmed the resident had not been assessed for bladder retraining.	F 315	MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for five (#9, #14, #12, #13,	F 323	F 323 Residents will receive adequate supervision and assistance devices to prevent accidents. A self release seat belt was replaced for resident # 9 the morning of August 2, 2011 by the Team Leader and the IDON verified its placement. The pressure pad for resident # 14 was immediately placed in the recliner on August 2, 2011 by the Team Leader. The nursing staff present were informed by the IDON that the pressure pad it to be in whatever chair the resident is using. On August 1, 2011 resident # 12 was immediately gotten out of bed by the Team Leader and nurse aide and put in a wheelchair with a pressure pad alarm. The alarm on her bed was then fixed by maintenance and is now working.	

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F 323	Continued From page 21 and #17) of twenty-nine residents reviewed. The findings included: Resident #9 was admitted to the facility on September 11, 2008, with diagnoses including Urinary Tract Infection, Congestive Heart Failure, and Senile Dementia. Medical record review of the fall risk assessment dated June 8, 2011, revealed the resident was at high risk for falls. Medical record review of a physician's order dated July 11, 2011, revealed the resident was to have a self-release belt applied when in the wheelchair due to unsteadiness. Observation on August 2, 2011, at 8:15 a.m., revealed the resident seated in a wheelchair, in the resident's room, without the self-release wheelchair belt in place. Observation and interview on August 2, 2011, at 8:19 a.m., with Licensed Practical Nurse (LPN) #2, revealed the resident seated in a wheelchair, in the resident's room, and confirmed the self-release wheelchair belt was not in place. Resident #14 was admitted to the facility on March 27, 2009, with diagnoses including Fractured Femur, Alzheimer's Disease, and Diabetes. Medical record review of the Care Plan reviewed on July 6, 2011, revealed "...Trauma-Falls...Assure pressure pad alarm is in place and functioning when in bed and chair..."	F 323	On August 2, 2011 resident # 17 was observation by the surveyor indicated the pressure pad was in the wheelchair with the alarm in the "on" position. Resident # 17's alarm remains in place and is working. The dycem for resident # 13 was replaced with another piece of dycem by the Team Leader Nurse. On August 16, 2011, all team leader nurses were in-serviced by IDON, an LPN, and Nurse Educator regarding assistive devices being on the resident appropriately and turned "on" when applicable, safety and adequate supervision to prevent falls. This began the one hundred percent education to all licensed nursing staff and nurse aides. The education was completed with all nurse aides and licensed staff on August 30, 2011. New or returning licensed staff members including licensed agency staff will receive education on the assistive devices prior to working on the units by the Nurse Educator, IDON or designee. Residents with existing assistive devices are identified by the Restraints/Physical forms generated from ECS. This form shows all residents using physical restraints or assistive devices. The Team Leader Nurse pulls this report form daily and conducts visual checks throughout the day to assure appropriate restraints or assistive device are on and in working order. This Restraint/Physical form is given to the IDON or designee daily indicating that all residents with assistive devices have them on and in the "on" position if applicable.	

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F 323	Continued From page 22 Observation on August 2, 2011, at 9:55 a.m., revealed the resident seated in a recliner, in the resident's room, without a pressure pad alarm in place. Observation and interview, on August 2, 2011, at 10:00 a.m., with Registered Nurse (RN) #1, revealed the resident seated in a recliner, in the resident's room, and confirmed the pressure pad alarm was not in place. Resident #12 was admitted to the facility on January 15, 2010, with diagnoses including Major Depressive Disorder, Hypertension, Arteriosclerotic Dementia, and Cerebrovascular Accident. Medical record review of a falls risk assessment dated June 18, 2011, revealed the resident was at high risk for falls. Medical record review of the Minimum Data Set dated July 18, 2011, revealed the resident had a history of falls. Medical record review of the physician's recapitulation orders dated August, 2011, revealed, "...pressure pad alarm when in bed unassisted transfer attempts..." Observation with Registered Nurse (RN) #2, on August 1, 2011, at 8:35 a.m., revealed the resident lying on the bed with the pressure pad alarm cord not attached to the alarm box.	F 323	The report indicates that these devices have been checked by the RN/LPN during that day. The results of the assistive devices audits are given to the IDON. The IDON or designee then tracks and trends these results and reviews the overall effectiveness of the system and for resident outcomes. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 323	Continued From page 23 Interview on August 1, 2011, at 8:35 a.m., with RN #2, in the resident's room, confirmed the pressure pad alarm cord was not attached to the alarm box. Resident #17 was admitted to the facility on March 27, 2011, with diagnoses including Dementia, Osteoporosis, Seizures, Hypertension, BiPolar Disease, and Degenerative Disk Disease. Medical record review of the Minimum Data Set dated June 16, 2011, revealed the resident required no assistance with decision making, had short term memory problems, and required moderate assistance with transfers. Review of the Physician's Orders dated March 22, 2011, revealed, "Pressure pad alarm when in a chair, when in bed for safety unassisted transfer attempts." Review of the facility's documentation dated March 26, 2011, revealed, "...Resident was seated in wheelchair across from station and was observed to have eyes closed and leaning forward and falling forward out of wheelchair...alarm sounding... a scrape to the left knee." Review of the facility's documentation revealed dycem was placed in the wheelchair on March 27, 2011. Review of a nursing note dated June 20, 2011, at 6:05 p.m., revealed, "...found on floor up against wall on back...Call light was on. Bed alarm was not plugged in. Resident had been out for a procedure today and alarm was not plugged back in at the time of arrival to the unit...Resident noted	F 323		

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F 323	Continued From page 24 to have a large hematoma on back of head, no laceration, hematoma approximately 4 inches in length...First Aide; Emergency Room..." Review of a nursing note dated June 20, 2011, at 11:33 p.m., revealed the resident was returned to the facility, with no new orders. Observation on August 2, 2011, at 4:00 p.m., revealed the resident sitting in a wheelchair, in the hall, with the pressure pad alarm in wheelchair and turned to the on position. Interview with the Team Leader of the west hall, on August 2, 2011, at 3:30 p.m., at the nursing station, confirmed the pressure pad alarm was not plugged in, at the time, of the fall on June 20, 2011. Resident #13 was admitted to the facility on August 7, 2009 with diagnosis including Closed Fracture of Neck of Femur, Senile Dementia, and Parkinson's Disease. Medical record review of the Minimum Data Set dated April 5, 2011, and July 18, 2011, revealed the resident required extensive assistance with one person physical assistance for bed mobility and transfer; did not ambulate in the room or corridor; required limited assistance with one person physical assistance for locomotion; and had experienced two or more falls without injury. Medical record review of the August 2011 Recapitulation Orders revealed "...Apply dycem in w/c (wheelchair) for safety AM (morning) PM (evening) and NOC (at night) first date 08/30/10..."	F 323		

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F 323	Continued From page 25 Medical record review of the care plans dated April 20, 2011, and July 20, 2011, and the Certified Nurse Aide care plan posted on the interior of the resident's closet revealed a problem of "...Trauma-Falls...Relatcd to: Decline in functional status...History of falls, senile dementia, and over reaches for items without calling staff to assist...All Staff: Resident to have dycem to w/c to prevent sliding from w/c..." Observation and interview, with Licensed Practical Nurse (LPN) #3, on August 2, 2011, at 2:34 p.m., revealed the resident in the resident's room seated in the wheelchair. Further observation revealed LPN #3 and Certified Occupational Therapy Assistant (COTA) #1 assisted the resident to a standing position. Upon removal of the wedge cushion observation revealed no dycem in the wheelchair. Interview with LPN #3 and COTA #1 on August 2, 2011, at 2:34 p.m., in the resident's room, confirmed the dycem was not in the wheelchair as ordered by the physician and per the care plan.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Equipment will be maintained in a sanitary manner. The microwave, can opener slot blade, floor mixer and legs to the floor mixer have been cleaned by the dietary staff and are absent of debris. A new cleaning schedule has been established (Attachment 12) On August 18, 2011 in-services were provided by the Dietary Manager to all dietary staff regarding the new cleaning	

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F 371	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain equipment in a sanitary manner. The findings included: Observation on August 1, 2011, beginning at 8:25 a.m., with the Certified Dietary Manager and Assistant Dietary Manager present, revealed the following: 1. The interior surface of the microwave had dried splattered debris present. Observation on August 2, 2011, at 7:30 a.m., revealed the interior of the microwave had dried splattered debris present. 2. The can opener slot, blade and blade contact area had a heavy accumulation of black, sticky debris. 3. The floor mixer was covered with plastic. Upon removal of the cover observation revealed the mixer beater arm had an area with a build-up of white dried debris. Further observation revealed the mixer legs had a heavy accumulation of white debris. Interview on August 1, 2011, beginning at 8:25 a.m., with the Certified Dietary Manager and Assistant Dietary Manager present during the observation, confirmed the microwave interior had dried splattered debris. Further interview confirmed the can opener slot, blade and blade contact area had a heavy accumulation of black, sticky debris. Further interview revealed the plastic cover meant the equipment was clean and	F 371	schedule. Any new or returning to work associates or agency personnel will be trained on this new cleaning schedule by the Dietary Manager or designee prior to working. The Dietary Manager or designee will visually monitor for the cleanliness of the equipment daily X 4 weeks, then weekly X 3 weeks (Attachment 13). If it is noted to be unsanitary, it will be cleaned immediately by the Dietary Manager or designee. The Dietary Manager or designee then tracks and trends these results and reviews the overall effectiveness of the system and for cleanliness. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 371	Continued From page 27 ready to use. Further interview confirmed the floor mixer beater arm had an area with a build-up of white dried debris and the mixer legs had a heavy accumulation of white debris. Interview with the Certified Dietary Manager on August 2, 2011, at 7:30 a.m., confirmed the microwave interior had dried splatter debris present.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F 441 Staff will wash hands appropriately. The ADON instructed the Team Leader Nurse of resident # 6 to re-clean around the PEG tube with wound cleanser (antimicrobial) and reapply bacitracin ointment to PEG tube on the day in question. Upon notification to Nursing administration by the survey team of the error, the (LPN # 6) nurse was immediately removed from administering further treatments. She was placed on suspension pending a complete investigation. She was terminated on August 8, 2011. On August 31, 2011, after almost a month of observation resident # 6's physician has determined there have been on skin infections related to this incident per a conversation with the IDON. The Nurse Educator or designee will in-service all employees regarding proper hand washing techniques, including before and after donning gloves, on or before August 24, 2011. Any new, or returning to work employee or agency staff will be in-	

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F 441	Continued From page 28 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure staff appropriately wash the hands after application of antibiotic ointment for one (#6) of twenty-nine residents reviewed. The findings included: Observation on August 2, 2011, at 7:52 a.m., revealed Licensed Practical Nurse (LPN) #6 applied gloves, administered medications to resident #6 through a feeding tube, and flushed the feeding tube with water. Continued observation revealed LPN #6 removed the gloves and without washing the hands, applied fresh gloves, removed a gauze pad from the feeding tube site and applied antibiotic ointment to the feeding tube site with a gloved finger of the right hand. Continued observation revealed LPN #6 changed the glove on the right hand without washing or sanitizing the hands, and reconnected the resident's tube feeding. Review of the facility's policy Hand Hygiene revealed "...Hand hygiene is generally considered	F 441	serviced prior to working on the units or in their designated areas. The staff will be monitored for appropriate hand washing techniques by the IDON, Nurse Educator and/or Team Leaders weekly X 4, then monthly X 3. Additionally, all staff will be monitored visually to ensure hands are washed when appropriate. Results of these monitors will be given to the Nurse Educator. The Nurse Educator or designee tracks and trends these results and reviews the overall effectiveness and outcomes of the system. The results of this tracking and trending are presented to the QI Team composed of the Medical Director, DON, ADON, Administrator, Restorative Nurse, MDS Nurse, Therapy Manager, Dining Manager, Activity Manager, Nurse Educator, Medical Records and Human Resources Manager at the QI meetings held monthly but no less than quarterly.	

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F 441	Continued From page 29 the most important single procedure for preventing healthcare-associated infections...Although antiseptics and other handwashing agents do not sterilize the skin, they can reduce microbial contamination..." Review of the facility's policy Using Gloves revealed "...Wash hands before applying and after removing gloves. Gloves do not replace hand hygiene..." Interview on August 2, 2011, at 8:15 a.m., with LPN #6, in the resident's room, confirmed the hands were not washed after applying antibiotic ointment to the resident's feeding tube site, and confirmed the hands were not washed each time the gloves were removed prior to applying fresh gloves.	F 441		